TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Carlos D. Kugler, M.D.

**Respondent Name**
ACE American Insurance Company

**MFDR Tracking Number**
M4-16-3115-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
June 13, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier is indicating that the level of service does not support the information submitted. The provider disagrees. The examinee was referred to the provider by Randi Lee, DC (chiropractor) who is the Designated Doctor for the examinee. The examinee was referred to Dr. West as this was an orthopedic surgical issue and the Designated Doctor felt that more information was needed that was outside of her scope of practice. This type of referral has also been recommended by the DWC in Designated Doctor Training. Dr. West was requested to perform an examination and determination for Evaluation of Medical Care… in this case, the provider billed an Office Consult that took in to consideration a comprehensive history, a comprehensive evaluation and medical decision making of high complexity. Determining the examinee's need for surgical intervention is a moderate severity as demonstrated in the original medical report."

**Amount in Dispute:** $332.32

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Based on the above information, CV will stand behind the 99205 denial…

The provider mentions this case as an orthopedic surgical issue and the determination of evaluation for medical care, however, regardless of the type or situation of an office visit, the medical note documentation shall support the billed CPT code per documentation guidelines. Without the supporting medical information, the billed CPT code cannot be reimbursed at the full fee schedule allowance."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 3, 2016 | Evaluation & Management, new patient (99205) | $332.32 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – (150) Payer deems the information submitted does not support this level of service.

**Issues**

1. What are the rules that determine reimbursement for the disputed service?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?

**Findings**

1. Carlos D. Kugler, M.D. is seeking reimbursement of $332.32 for procedure code 99205. Reimbursement for evaluation and management codes is subject to the fee guidelines for professional medical services found in 28 Texas Administrative Code §134.203(b)(1), which states, in pertinent part:

   > for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…

2. ACE American Insurance Company denied the disputed service with claim adjustment reason code 15 – "(150) PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE." The American Medical Association (AMA) CPT code description for 99205 is:

   > Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

   The 1997 Documentation Guidelines for Evaluation & Management Services, published by the Centers for Medicare and Medicaid Services (CMS) found at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf puts forth the requirements to meet the AMA CPT code description presented. The division will review the submitted documentation to determine if the requirements, as outlined by the 1997 Documentation Guidelines, were met.

   Documentation of a Comprehensive History:

| | Requirement | Guideline Elements | Documented Elements | Requirement Met? |
|---|---|---|---|---|
| Chief Complaint | Statement describing the symptom, etc. | 1 statement | "The examinee presents today with complaints to the following areas: Right knee, right toe." | Yes |
| Extended HPI | At least four elements of the HPI. | Location | x | Yes |
| | | Quality | x | |
| | | Severity | x | |
| | | Duration | x | |
| | | Timing | x | |
| | | Context | x | |
| | | Modifying Factors | x | |

| | | | | |
|---|---|---|---|---|
| | | Assoc. Signs/Symptoms | x | |
| Complete ROS | At least ten organ systems. | Constitutional | | No |
| | | Eyes | | |
| | | ENT | | |
| | | Cardio./Vasc. | | |
| | | Respiratory | | |
| | | GI | | |
| | | GU | | |
| | | Musculoskeletal | x | |
| | | Integumentary | | |
| | | Neurological | x | |
| | | Psychological | | |
| | | Endocrin | | |
| | | Hem./Lymph. | | |
| | | Allergy/Immun. | | |
| | | All Others Neg. | | |
| Complete PFSH | At least one specific item from each of the three history areas. | Past | x | No |
| | | Family | | |
| | | Social | x | |

The Guidelines state, "To qualify for a given type of history all three elements in the table must be met."

Submitted documentation supports the presence of a chief complaint and an extended history. Because the provider documented only two systems, a complete review of systems was not supported. The provider documented only two areas of history, therefore, a complete PFSH was not supported for a new patient office visit.

The division finds that the submitted documentation does not support a Comprehensive Medical History, which is required for procedure code 99205.

Documentation of a Comprehensive Examination:

The 1997 Documentation Guidelines requires a comprehensive examination to include "a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)." Review of the submitted report finds that the documented examination most closely supports a single organ system examination for the musculoskeletal system. A "*comprehensive* examination [for a single organ system] …should include performance of all elements [of the Musculoskeletal Examination table]."

| System/Body Area | Guideline Elements of Examination | Documented Elements |
|---|---|---|
| Cardiovascular | Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness) | |
| Lymphatic | Palpation of lymph nodes in neck, axillae, groin, and/or other location | |
| Skin | Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café-au-lait spots, ulcers) in four of the following six areas: 1) head and neck, 2) trunk, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, 6) left lower extremity. Note: **For the comprehensive level, the examination of all four anatomic areas must be performed and documented**... | |
| Neurological/ Psychiatric | Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, ...) | |
| | Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski) | x |
| | Examination of sensation (e.g., by touch, pin, vibration, proprioception) | x |
| | Orientation to time, place and person | |
| | Mood and affect (e.g., depression, anxiety, agitation) | x |

| | | |
|---|---|---|
| Constitutional | Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) | x |
| | General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) | x |
| Musculoskeletal | Examination of gait and station | x |
| | Examination of joint(s), bone(s), and muscle(s)/tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity… Note: **For the comprehensive level of examination, <u>all four elements</u> identified by a bullet must be performed and documented for <u>each of four anatomic areas</u>**... | |
| | Inspection, percussion and/or palpation with notation of any misalignment, asymetry, crepitation, defects, tenderness, masses or effusions | |
| | Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation or contracture | |
| | Assessment of stability with notation of any dislocation (luxation), subluxation or laxity | |
| | Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements | |

A review of the submitted report finds that nine of the required elements were not sufficiently documented. Therefore, submitted documentation does not support a Comprehensive Examination, which is required for procedure code 99205.

<u>Documentation of Decision Making of High Complexity</u>:

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The submitted report is considered for the presence of the following elements:

- *Number of diagnoses or treatment options*

| **Problem(s) Status** | **Number** | **Documented** |
|---|---|---|
| Self-limited or minor (stable, improved or worsening) | Max 2 | |
| Est. problem (to examiner); stable, improved | | |
| Est. problem (to examiner); worsening | | |
| New problem (to examiner); no additional workup planned | Max 1 | x |
| New problem (to examiner); additional workup planned | | |

Review of the submitted documentation finds that a new problem to the examiner was presented with no additional workup planned, meeting the documentation requirements of moderate complexity. The performance of the electromyography and nerve conduction study was not considered, as the decision to perform this testing was the purpose of the referral and not a result of the examination. Documentation does not support that this element was met.

- *Amount and/or complexity of data to be reviewed*

| Reviewed Data | Documented |
|---|---|
| Review and/or order of clinical lab tests | |
| Review and/or order of tests in the radiology section of CPT | |
| Review and/or order of tests in the medicine section of CPT | |
| Discussion of test results with the performing physician | |
| Decision to obtain old records and/or obtain history from someone other than patient | |
| Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider | x |
| Independent visualization of image, tracing or specimen itself (not simply review of report) | |

Review of the documentation finds that the requestor reviewed and summarized the relevant findings from other providers. The documentation supports that this element did not meet the criteria for high complexity of data reviewed.

- *Risk of complications and/or morbidity or mortality*

Review of the submitted documentation finds that presenting problems include one acute injury and recommendation for elective surgery with no identified risk factors, which present a moderate level of risk, per the Table of Risk found in the 1997 Documentation Guidelines. "The highest level of risk in any one category…determines the overall risk." The documentation does not support that this element met the criteria for high risk.

The 1997 Documentation Guidelines requires that "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." A review of the submitted documentation does not support that this component of procedure Code 99205 was met.

Because no components of CPT Code 99205 were met, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Laurie Garnes<br>Medical Fee Dispute Resolution Officer | November 21, 2016<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.